tion was ultrasound (80%), followed by an MRI (60%), and finally, CT (30%). Pharmaceutical hormonal suppression prior to definitive treatment consisted of GnRH agonist/antagonists (60%), oral progestin (30%), and continuous OCP's (10%). For undiagnosed patients, surgical management primarily occurred via a two-step process, though 22% of the patients underwent a one-step technique. Definitive surgical management of the obstruction occurred 23 months (± 12) after initial diagnosis. The procedure took 7.8 hours (± 4.2) to complete and most commonly required three surgeons from pediatric and adolescent gynecology, pediatric surgery, and pediatric urology. Average postoperative hospitalization was 7 days (± 3). The most common postoperative complications were restenosis (33%), vaginal infection (11%), and fistula (11%). The cohort underwent an average of three total surgeries and were followed for about 3.4 years (± 3.1) after definitive surgery.

Comments: Our case series provides new information regarding the diagnosis and definitive management of 10 girls with complex obstructive Müllerian anomalies. Management of this type of anomaly requires hormonal suppression, multiple prolonged surgeries, and multidisciplinary care. Further elucidation regarding the presentation and care for this population will aid in swift diagnosis and a stepwise standardization of management.

Supporting Figures or Tables
https://www.abstractscorecard.com/uploads/Tasks/upload/19245/RGXGDRUQ-1372492-1-ANY.pdf
https://www.abstractscorecard.com/uploads/Tasks/upload/19245/RGXGDRUQ-1372492-2-ANY.pdf

18. Non-healing vulvar ulcer in a toddler

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Background: Although most vulvar ulcers represent an acute process, persistent vulvar ulcers require the pediatric and adolescent gynecologist (PAG) to consider systemic and neoplastic processes. The objective of this case report is to describe workup of non-healing vulvar ulcers in the prepubertal patient.

Case: The patient was referred to a tertiary care PAG clinic at the age of 16 months for evaluation of vulvar lesions. She was born at 40w1d gestation by emergent cesarean section for fetal bradycardia. During labor, her mother had an oral lesion and positive herpes simplex virus (HSV) IgG, with otherwise normal serology. Maternal history was negative for vulvovaginal lesions as was physical exam at the time of labor. At birth, the patient had a vulvar lesion noted and was treated with acyclovir until one month of age for suspicion of congenital HSV infection. At 12 months of age, the vulvar lesion persisted and was further characterized by an infectious disease specialist as bilateral, raised, and rubbery with demarcated margins and fungating surface, and diagnosed as a congenital anomaly. HSV swab was negative. At 16 months of age in PAG clinic, the patient's mother described yellowish exudate from the lesion. There was no bleeding and the patient was easily consolable after wiping. No change in size had been noted over time. No other gastrointestinal or systemic symptoms were present. The patient had been seen by otolaryngology for enlarged adenoids, treated with Flonase. Family history was otherwise unremarkable with no known autoimmune disease. On physical examination, the sexual maturity rating was Stage 1. At 5 and 7 o'clock on the labia majora, symmetric bilateral ulcerations were seen measuring approximately 1cm each, with white exudate at the bases, no bleeding and no surrounding erythema (see Figure 1). Workup of non-healing ulcers present from birth requires biopsy (which for this patient has been delayed due to family circumstances) to rule out neoplastic processes such as granular cell tumor or nodular fasciitis. Other etiologies under consideration include infectious (eg. herpes simplex virus, syphilis, Epstein-Barr virus, cytomegalovirus, mycoplasma, bacterial and fungal cultures), autoimmune (eg. Crohn's) and nutritional deficiencies (eg. vitamins A, B12, C, D, folate, zinc, copper).

Comments: For non-healing vulvar ulcers in a toddler, the differential diagnosis should be widened from infectious causes to include autoimmune conditions, nutritional deficiencies, and neoplastic processes. If the biopsy for this patient is consistent with granular cell tumor or nodular fasciitis, it will be the first described case of congenital presentation of these vulvar neoplasms.

Supporting Figures or Tables

19. Affirmative medical treatment and contraception choice in a cohort of gender diverse adolescents assigned female at birth

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Background: In the past two decades, there has been a rapid increase in the number of referrals at gender diversity clinics. Youth and their families may be presented with a wide range of cosmetic, medical, and surgical treatments. Little is known about the specific needs of gender diverse youth assigned female at birth (AFAB) receiving care in these clinics. Our goal was to describe treatment provided to this specific population and assess clinical outcomes.

Methods: We conducted a retrospective cohort study in a large tertiary care gender diversity clinic located in Quebec, Canada. All patients assigned female at birth seen at the clinic between November 2016 and May 2021 were included. We analyzed patients from 10 and 18 years-old at the time of the initial consultation. A retrospective chart review was completed regarding population characteristics, medical and surgical treatments with their respective outcomes according to clinical and biochemical criteria. Local IRB approval was obtained.